Clarinda Community School District
Enrollment/ Emergency Form

Student_____ Grade_____ Date of Birth_____ Male/Female_____

Home Phone_____ Address_____City,State,Zip_____

Family Information:

List Name and Relationship to child:	Address	Home Phone	Cell Phone	Employer	Work Phone	Email address	Has contact with student Yes/No
Parent/Guardian Living with Student:							
Spouse of Parent/Guardian Listed Above:							
AND							
Parent/Guardian Not Living with Student:							
Spouse of Parent/Guardian Listed Above:							

Please Mark if student: is **Open Enrolled** Yes/ No in **Band** Yes/ No If Yes, list instrument _____ in **Special Education** Yes/ No has a **504 plan** Yes/No

Student lives with: __Parent(s) __Caretaker __Legal Guardian **Student lives in:** __Parent home __Relatives/Friends home __Hotel __Other

Contact Information (please list LOCAL contacts):

Ask about texting notifications!

Child Care_____ Child Care Phone_____

Emergency Contact #1_____ Phone (1) _____ Phone (2) _____

Emergency Contact #2_____ Phone (1) _____ Phone (2) _____

Emergency Contact #3_____ Phone (1) _____ Phone (2) _____

For Residents New to Clarinda: What Brought You to Clarinda: ___Employment ___Relatives ___Other - please list _____

School Medical Registration Form – Health History

Please list a local provider that you prefer in the case of an emergency.

Family Doctor _____ Date of last exam _____ Does student have a current school physical Y/N

Dentist _____ Date of last exam _____

Eye Doctor _____ Date of last exam _____

***In the event of an emergency, 911 will be called and your child will be taken to Clarinda Regional Health Center.**

List other doctors, specialists, counselors (local or out-of-town): _____

Allergies (list allergy and type of reaction): _____

Medications taken routinely: _____

Will your child take medicine at school: Yes/No If yes, what medication? _____

* Note- All medications given at school must be supplied by the parent in the original container and a medication permit form must be completed and signed by the parent.

1. Does your child have health insurance? Yes/No Provider Name: _____

2. Do you have any concerns about your child's general health? (eating, sleeping, weight, etc.) Yes/No

3. Does your child have any chronic illness or medical condition? (seizures, asthma, heart condition, ADHD, etc.) Yes/No

4. Has your child had any serious accidents? (burns, head injury, broken bones, etc.) Yes/No

5. Does your child have any problems with:

Hearing	Yes/No	Vision	Yes/No	Does your child wear glasses?	Yes/No
Speech	Yes/No	Physical Disabilities	Yes/No		

Explain all yes answers in the space provided below:

_____

_____

_____

This form will be added to the student's health file and shared with appropriate school staff.

Parent Signature: _____*Date:* _____

605.6E1 Internet Access Permission Letter

Dear Student, District Personnel or Volunteer/Other:

As part of the School District's continuing effort to provide all students, employees and volunteers with high quality, up-to-date educational resources, we have internet access on the computers in all Clarinda Community Schools.

Please know the entire administration and staff of the school district is committed to ensuring the use of computers and internet access for only educationally sound and productive learning activities. During school activities teachers and other staff will guide students toward appropriate materials.

The School Board has adopted a Responsible Use Policy to comply fully with the federal Children's Internet Protection Act. Each school will review the information in the District Computer, Network and Internet Policy in age-appropriate language before allowing him/her to use the Internet on a school computer. We also request that you review the policy with your child to reinforce the importance of internet safety for all children. One rule that we consistently emphasize is that students, employees and volunteers should never give out personal information (home address, phone numbers, etc.) about themselves or others when using the internet.

I understand, accept and agree to abide by the following terms and conditions:

- I have received and familiarized myself with the District Computer, Network and Internet Policy approved by the Clarinda Community School Board.
- I will abide by the Terms and Conditions of the District Computer, Network and Internet Policy in my use of computing devices at school.
- I understand and accept that the purpose of the Clarinda Community Schools network is educational, and other uses are inappropriate.
- I understand and accept that the use of the School Community Schools network is a privilege and not a right.
- I understand that there is no guarantee of privacy using District technology.
- I understand that violation of the District Computer, Network and Internet Policy may result in disciplinary action ranging from a verbal or written warning to criminal prosecution.
- I understand that if it is determined that a device is lost or damaged as a result of my negligence, that I am responsible for the cost to replace or repair the device.

I have read Policy 605.6 Internet Acceptable Use and Policy 605.6E1 Internet Access Permission Letter and agree to abide by these provisions. I understand that violation of these provisions may constitute suspension or revocation of internet privileges and discipline. School personnel who violate these provisions may be subject to disciplinary action including immediate discharge or termination of employment.

This agreement will be in effect for as long as the student, employee or volunteer/other attends, is employed, volunteers, or participates at Clarinda Community School District and may be revoked at any time by the parent/guardian or administration. Procedures are subject to change at any time at the discretion of the superintendent.

Reference Policy 605.6

Date:
Student
Print Student Name:
Student Signature:
Parent
Print Parent/Guardian Name:
Signature Parent/Guardian:

Elementary Dismissal Form

Student Name: _____ Grade: _____ Teacher: _____

Parent Name: _____ Address: _____ Phone: _____

Mark only ONE. Choose the usual procedure. Send a note or call the office with changes.

_____ My child walks home.

_____ My child is picked up at school.

_____ My child rides the bus to Noah's Ark Daycare.

_____ My child rides the bus to Grandma's House Daycare.

_____ My child ride the McKinley Shuttle.

_____ My child rides the Lutheran School Shuttle.

_____ My child rides the Lied Center Shuttle.

_____ My child rides the High School Shuttle.

_____ My child rides a country bus route HOME.
Bus driver _____ bus # _____
AM/PM _____

If it is necessary to dismiss early because of weather or other reasons my child should:

_____ Follow his/her usual procedure for leaving school.

_____ My child is to go with _____ Phone _____

****

Permission Form

By signing this form I am agreeing to the following:

1. My child can go on local field trips during the school year.
2. My child can have his/her picture taken for the school newsletter, school website, and local newspaper.
3. My child can have our address and phone number given to classmates for party invitations.

_____ _____

(Parent or Guardian) **(Date)**

ETHNICITY/RACE

Student Name: _____

Is this student Hispanic/Latino? (*Choose only one*)

- ☐ **No, not Hispanic/Latino**
- ☐ **Yes, Hispanic/Latino** (A person of Cuban, Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race.)

The above part of the question is about ethnicity, not race. No matter what you selected above, **please continue to answer the following** by marking one or more boxes to indicate what you consider your student's race to be.

What is the student's race? (*Choose one or more*)

- ☐ **American Indian or Alaska Native** (A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.)
- ☐ **Asian** (A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)
- ☐ **Black or African American** (A person having origins in any of the black racial groups of Africa.)
- ☐ **Native Hawaiian or Other Pacific Islander** (A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)
- ☐ **White** (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

_____

Signature

School District: _____ Date completed: _____

Migrant Education Parent Form

The answers to this form will help determine if your child (ren) is eligible to receive supplemental services from the Migrant Program.

Name of Parent(s) or Legal Guardian(s)		
Current Address: City:	State:	Zip Code:
Phone Number:		
Best Time to be Contacted:		

1. Has your family moved in order to work in another city, country, or state in the last three (3) years YES___ NO____
2. If so, what is the date your family arrived in the city/town? _____
3. Has anyone in your family been involved in one of the following jobs, either full or part-time or temporarily during the last three (3) years? (Check all that apply)

   [ ] Agriculture; planting/picking fruits and vegetables
   [ ] Planting, Growing, Detasseling or Farm labor
   [ ] Processing/packing agricultural products
   [ ] Dairy/Poultry/Egg/Livestocks
   [ ] Meatpacking/Meat processing
   [ ] Fishing or fish farms
   [ ] Other (Please specify the job):_____

4. Name of student(s) Name of School Grade

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Thank you!

Please return this form to the school. Note for the school/district: When both "yes" to #1 and one or more of the boxes from #3 is/are checked, please give this form to the migrant liaison to scan and email to alex.johnson@iowa.gov. Please file original in student's records. For additional questions regarding this form, please contact Geri McMahon at 515-2813944 (geri.mcmahon@iowa.gov) or Susan Selby at 515-281-4732 (susan.selby@iowa.gov) .

Clarinda School District
Home Language Survey

Date_____ School _____Grade_____

Student Name: _____
(last) (first) (middle)

*Place of Birth: _____

Father/Guardian Name: _____

*Employment: _____

Mother/Guardian Name: _____

*Employment: _____

Address: _____

Phone Number : _____ (home) _____(work)

1. Was English the first language your son/daughter learned to speak? _____Yes _____No

2. What language do you speak to your son/daughter? (father) _____

(mother) _____

3. What language does your son/daughter speak to you? _____

4. What language does your son/daughter speak to other relatives? _____

5. What language does your son/daughter speak to friends? _____

6. In what language would you prefer to receive

communication from the school? _____

I understand my son/daughter, _____, will receive English language proficient testing. I will be notified if my son/daughter qualifies for English Language Learner (ELL) program services. I understand that at the time I have the right to refuse ELL services for my child. However, I can request services at a later date.

_____ _____
(Parent/Guardian Signature) (Date)

OFFICE USE ONLY: Refer for:

Initial ELL Identification: _____ Initial Migrant Identification: _____

MILITARY CONNECTED STATUS

Revised 10/24/13

STUDENT NAME:

CHECK ONE

- ◯ **Neither Parent or Guardian is serving in any military service**
- ◯ **A Parent or Guardian is serving in the National Guard but is not deployed**
- ◯ **A Parent or Guardian is serving in the Reserves but is not deployed**
- ◯ **A Parent or Guardian is serving in the National Guard and is currently deployed**
- ◯ **A Parent or Guardian is serving in the Reserves and is currently deployed**
- ◯ **A Parent or Guardian is serving in the military on active duty but is not deployed**
- ◯ **A Parent or Guardian is serving in the military on active duty and is currently deployed**
- ◯ **The student's Parent or Guardian died while on active duty within the last year**

COMMENTS: _____

_____

_____

_____

_____

Infant, Toddler, Preschool Age – Child Health Exam Form

PARENTS/GUARDIAN COMPLETE PAGES 1 and 2 – Child Information

Child's name	Child's birthdate	Name of center, provider, or preschool Telephone #
Parent 1 name	Parent 2 name	
Child home address #1		Telephone # 1
Child home address #2		Telephone #2
Where parent # 1 works	Work address	~~Home~~ phone # ~~Work~~ # ~~Pager~~ # ~~Cellular~~ # ~~Home~~ email ~~Work~~ email
Where parent # 2 works	Work address	~~Home~~ phone # ~~Work~~ # ~~Pager~~ # Cellular # Home email Work email

In the event of an emergency, the child care provider is authorized to obtain EMERGENCY MEDICAL or DENTAL CARE even if the child care center is unable to immediately make contact with the parent/guardian. ☐ YES ☐NO

During an emergency the child care provider is authorized to contact the following person when parent or guardian cannot be reached.

Parent/Guardian Signature: _____ Date _____

Alternate emergency contact person's name:_____ Phone number:

Relationship to child: Cellular number:

Child's doctor's name	Doctor telephone # 1	Hospital choice
Doctor's address	After hours telephone #	Does child have health insurance? ☐Yes, Company _____ ~~ID #~~
Child's dentist's name	Dentist Telephone # 1	Does child have dental insurance? ☐Yes, Company _____ ~~ID#~~
Dentist's Address	After hours telephone #	☐ **NO, we do not have health insurance.** ☐ **NO, we do not have dental insurance.**
Other health care specialist name Type of specialty	Telephone #	☐ **Please help us find health or dental insurance.**

PARENTS COMPLETE THIS PAGE

Parents: Tell us about your child's health. Place an **X** in the box ☒ if the sentence applies to your child. Check *all* that apply to your child. This will help your doctor plan your child's physical exam.

Growth

☐ I am concerned about my child's growth.

Appetite

☐ I am concerned about my child's eating / feeding habits or appetite.

Rest -

☐ I am concerned about the amount of sleep my child needs.

Illness/Surgery/Injury - My child

☐ had a serious illness, injury, or surgery.
Please describe.

Physical Activity - My child

☐ must restrict physical activity.
Please describe.

Development and Learning

☐ I am concerned about my child's behavior, development, or learning.
Please describe:

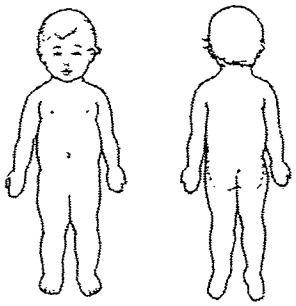
☐ **Medication** - My child takes medication. List the name, time medication taken, and the reason medication prescribed.

Child's Name: _____

Body Health - My child has problems with

☐ Skin, birthmarks, Mongolian spots, hair, fingernails or toenails.

Map and describe color/shape of skin markings birthmarks, scars, moles



☐ Eyes \ vision, glasses
☐ Ears \ hearing, hearing aides or device, earaches, tubes in ears
☐ Nose problems, nosebleeds, runny nose
☐ Mouth, teething, gums, tongue, sores in mouth or on lips, mouth-breathing, snoring
☐ Frequent sore throats or tonsillitis
☐ Breathing problems, asthma, cough, croup
☐ Heart, heart murmur
☐ Stomach aches, upset stomach, colic, spitting up
☐ Using toilet, toilet training, urinating
☐ Bones, muscles, movement, pain with moving
☐ Mobility, uses assistive equipment
☐ Nervous system, headaches, seizures, or nervous habits (like twitches)
☐ Needs special equipment. *Please describe*:

☐ **Allergies**-My child has allergies (medicine, food, dust, mold, pollen, insects, animals, etc.).

Please describe:

Parent questions or comments for the health care provider:

Iowa Child Care Infant, Toddler, Preschool Age – Child Health Exam Form

HEALTH PROFESSIONAL COMPLETE THIS PAGE[1]

Child's Name: _____

Birthdate: **Age today:**

Date of Exam:_____

Height/Length:

Weight:

Head Circumference-for children age 2 yr and under:

Blood Pressure-start @ age 3 yr:

Hgb or Hct-anytime between 6-9 mo:

Blood Lead Level-start @ 12 mo:

Sensory Screening:

Vision: Right eye _____ Left eye _____

Hearing: Right ear _____ Left ear _____

Tympanometry (may attach results)

Developmental Screening[2]:

Developmental screening results:

Autism screening results:

Psychosocial/behavioral results

Developmental Referral Made Today: □Yes □No

Exam Results: *(n = normal limits) otherwise describe*

HEENT

Oral/Teeth

Oral Health/Dental Referral Made Today: ☐Yes ☐ No

Heart

Lungs

Stomach/Abdomen

Genitalia

Extremities, Joints, Muscles, Spine

Skin, Lymph Nodes

Neurological

Space is available on back page for detailed comments or instructions pertaining to enrollment at child care or preschool.

[1] Iowa Child Care Regulations require an admission physical exam report within the previous year. Annually thereafter, a statement of health condition signed by an approved health care provider. The American Academy of Pediatrics has recommendations for frequency of childhood preventative pediatric health care (RE9939, March 2000) www.aap.org

[2] Developmental screening procedures were expanded to include autism, developmental surveillance, and psychosocial/behavioral screening July 2009 by the Iowa EPSDT Medicaid program. Toll-free 800-383-3826.

Allergies

Environmental:
Medication:
Food:
Insects:
Other:

Immunization: May attach a copy of Iowa Department of Public Health Immunization Certificate

DtaP/DTP/Td	MMR
Hepatitis B	Pneumococcal
HIB	Varicella
Polio	Other
Influenza	

TB testing (only for high-risk child)

Medication: Health professional authorizes the child may receive the following medications while at child care or preschool: (include *over-the-counter* and *prescribed*)

Medication Name	Dosage
☐ Cough medication	
☐ Diaper crème:	
☐ Fever or Pain reliever:	
☐ Sunscreen:	
☐ Other	

Other Medication should be listed with written instructions for use in child care.

Referrals made:

☐ Referred to ***hawk-i*** today 1-800-257-8563

☐ Other: _____

Health Provider Assessment Statement:

☐The child may participate in developmentally appropriate child care/preschool with ***NO*** health-related restrictions.

☐ The child may participate in developmentally appropriate child care/preschool ***with the following restrictions***:

May use stamp

Signature _____

Circle the Provider Credential Type: MD DO PA ARNP

Address: Telephone:

Health Care Provider comments or instructions: **Child's name:** _____

Iowa Health Care Provider -- Guide to Iowa Recommendations for Preventive Pediatric Health Care[3]

Health Provider's Guide		AGE[4]											
		1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	2 yr	3 yr	4 yr	5 yr
History:	Initial and Interval	●	●	●	●	●	●	●	●	●	●	●	●
Physical Exam		●	●	●	●	●	●	●	●	●	●	●	●
Measurement:	Height/ Weight	●	●	●	●	●	●	●	●	●	●	●	●
	Head Circumference	●	●	●	●	●	●	●	●	●			
	Blood Pressure	Risk Assessment									●	●	●
Nutrition	Assess/Educate	●	●	●	●	●	●	●	●	●	●	●	●
Oral Health Assessment[5]		●	●	●	●	●	●	●	●	●	●	●	●
Development and Behavioral Assessment		●	●	●	●	●	●	●	●	●	●	●	●
	Developmental Screening					●			●		●		
	Autism Screening								●	●			
	Developmental Surveillance	●	●	●	●		●	●		●		●	●
	Psychosocial/behavioral Assessment	●	●	●	●	●	●	●	●	●	●	●	●
Sensory Screen:	Vision	S	S	S	S	S	S	S	S	S	O	O	O
	Hearing[6]	S	S	S	S	S	S	S	S	S	S	O	O
Immunizations:	*per Iowa schedule*[7]	●	●	●	●	●	●	●	●	●	●	●	●
Lab:	Hemaglobinopathy/Metabolic Screen	●[8]											
	Hematocrit or Hemoglobin					● →		◆ →					→
	Urinalysis												●
	Lead Test						●		◆	●[9]	◆	◆	◆
	Cholesterol Screen									◆ →			→
	TB test[10]						◆	→					→
Family Guidance:	Injury Prevention	●	●	●	●	●	●	●	●	●	●	●	●
	Child Car Seat Counseling	●	●	●	●	●	●	●	●	●	●	●	●
	Tricycle Helmet Counseling									●	●	●	●
	Sleep Position Counseling	●	●	●	●	●	●						
	Nutrition & Physical Activity Counseling	●	●	●	●	●	●	●	●	●	●	●	●
	Violence Prevention	●	●	●	●	●	●	●	●	●	●	●	●
	Child Development Guidance	●	●	●	●	●	●	●	●	●	●	●	●
		1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	2 yr	3 yr	4 yr	5 yr

Key: ● = to be performed
◆ = to be performed for high-risk children
→ = Range in which the task may be completed

S = Subjective, by history
O = Objective, by standard testing

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[3] The periodicity schedule was revised July 2009 by the Iowa Medicaid EPSDT program. http://www.idph.state.ia.us/hpcdp/epsdt_care_for_kids.asp

[4] If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.

[5] Oral Health Assessment consists of dental history; recent concerns, pain or injury; visual inspection of hard and soft tissues of oral cavity; and dental referral based on risk assessment. http://www.idph.state.ia.us/hpcdp/oral_health.asp or toll-free: 866-528-4020.

[6] Infants born in Iowa should have record of results from newborn hearing screening. http://www.idph.state.ia.us/iaehdi/default.asp or toll-free 800-383-3826.

[7] Iowa Immunization program 1-800-831-6293.

[8] All newborns should receive metabolic screening during neonatal period. www.idph.state.ia.us/genetics

[9] Lead testing should be done at 12 & 24 months. Testing may be done at additional times for children determined at risk. Lead program 1-800-972-2026.

[10] TB testing for only at-risk children, Iowa TB program 1-800-383-3826.

Child's Name _____

List names of people who can access your child's health records. Please include their relationship to your child.

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

Approval for school to apply insect repellant (provided by parent) Yes No

Approval for school to apply sunscreen (provided by parent) Yes No

Parent Signature_____ Date_____

Iowa Department of Public Health
Certificate of Immunization

Name Last: _____ First: _____ Middle: _____ Date of Birth: _____

Parent/Guardian: _____ Address: _____ Phone: (____)_____

I certify that the above named applicant has a record of age-appropriate immunizations that meet the requirement for licensed child care or school enrollment.

Signature: _____ Date: _____

Physician, Physician Assistant, Nurse, or Certified Medical Assistant

A representative of the local Board of Health or Iowa Department of Public Health may review this certificate for survey purposes.

	Vaccine	Date Given	Doctor / Clinic / Source
Diphtheria, Tetanus, Pertussis DTaP/DTP/DT/ Td/Tdap			
Polio IPV/OPV			
Measles, Mumps, Rubella MMR			
***Haemophilus influenzae* type b** Hib			
Hepatitis B			

	Vaccine	Date Given	Doctor / Clinic / Source
Varicella Chicken Pox If patient has a history of natural disease write "Immune to Varicella"			
Pneumococcal PCV/PPV			
Meningococcal MCV4/MPSV4			
Hepatitis A			
Rotavirus			
Human Papilloma Virus HPV			
Other			

April 2012

IMMUNIZATION REQUIREMENTS

Applicants enrolled or attempting to enroll shall have received the following vaccines in accordance with the doses and age requirements listed below. If, at any time, the age of the child is between the listed ages, the child must have received the number of doses in the "Total Doses Required" column.

Institution	Age	Vaccine	Total Doses Required
Licensed Child Care Center	Less than 4 months of age	This is not a recommended administration schedule, but contains the minimum requirements for participation in licensed child care. **Routine vaccination begins at 2 months of age.**	
	4 months through 5 months of age	Diphtheria/Tetanus/Pertussis	1 dose
		Polio	1 dose
		haemophilus influenzae type B	1 dose
		Pneumococcal	1 dose
	6 months through 11 months of age	Diphtheria/Tetanus/Pertussis	2 doses
		Polio	2 doses
		haemophilus influenzae type B	2 doses
		Pneumococcal	2 doses
	12 months through 18 months of age	Diphtheria/Tetanus/Pertussis	3 doses
		Polio	2 doses
		haemophilus influenzae type B	2 doses; or 1 dose received when the applicant is 15 months of age or older.
		Pneumococcal	3 doses if the applicant received 1 or 2 doses before 12 months of age; or 2 doses if the applicant has not received any previous doses or has received 1 dose on or after 12 months of age.
	19 months through 23 months of age	Diphtheria/Tetanus/Pertussis	4 doses
		Polio	3 doses
		haemophilus influenzae type B	3 doses, with the final dose in the series received on or after 12 months of age, or 1 dose received when the applicant is 15 months of age or older.
		Pneumococcal	4 doses; or 3 doses if the applicant received 1 or 2 doses before 12 months of age; or 2 doses if the applicant has not received any previous doses or has received 1 dose on or after 12 months of age.
		Measles/Rubella[1]	1 dose of measles/rubella-containing vaccine received on or after 12 months of age; or the applicant demonstrates a positive antibody test for measles and rubella from a U.S. laboratory.
		Varicella	1 dose received on or after 12 months of age if the applicant was born on or after September 15, 1997, unless the applicant has had a reliable history of natural disease.
	24 months and older	Diphtheria/Tetanus/Pertussis	4 doses
		Polio	3 doses
		haemophilus influenzae type B	3 doses, with the final dose in the series received on or after 12 months of age; or 1 dose received when the applicant is 15 months of age or older. Hib vaccine is not indicated for persons 60 months of age or older.
		Pneumococcal	4 doses if the applicant received 3 doses before 12 months of age; or 3 doses if the applicant received 2 doses before 12 months of age; or 2 doses if the applicant received 1 dose before 12 months of age or received 1 dose between 12 and 23 months of age; or 1 dose if no doses had been received prior to 24 months of age. **Pneumococcal vaccine is not indicated for persons 60 months of age or older.**
		Measles/Rubella[1]	1 dose of measles/rubella-containing vaccine received on or after 12 months of age; or the applicant demonstrates a positive antibody test for measles and rubella from a U.S. laboratory.
		Varicella	1 dose received on or after 12 months of age if the applicant was born on or after September 15, 1997, unless the applicant has had a reliable history of natural disease.
Elementary or Secondary School (K-12)	4 years of age and older	Diphtheria/Tetanus/ Pertussis[3, 4]	3 doses, with at least 1 dose of diphtheria/tetanus/pertussis-containing vaccine received on or after 4 years of age if the applicant was born on or before September 15, 2000; or 4 doses, with at least 1 dose of diphtheria/tetanus/pertussis-containing vaccine received on or after 4 years of age if the applicant was born after September 15, 2000, but before September 15, 2003; or 5 doses with at least 1 dose of diphtheria/tetanus/pertussis-containing vaccine received on or after 4 years of age if the applicant was born on or after September 15, 2003.[2] DTaP is not indicated for persons 7 years of age and older, therefore, a tetanus-and diphtheria-containing vaccine should be used.
		Polio[6]	3 doses, with at least 1 dose received on or after 4 years of age if the applicant was born on or before September 15, 2003; or 4 doses, with at least 1 dose received on or after 4 years of age if the applicant was born after September 15, 2003.[5]
		Measles/Rubella[1]	2 doses of measles/rubella-containing vaccine; the first dose shall have been received on or after 12 months of age; the second dose shall have been received no less than 28 days after the first dose; or the applicant demonstrates a positive antibody test for measles and rubella from a U.S. laboratory.
		Hepatitis B	3 doses if the applicant was born on or after July 1, 1994.
		Varicella	1 dose received on or after 12 months of age if the applicant was born on or after September 15, 1997, but born before September 15, 2003, unless the applicant has had a reliable history of natural disease; or 2 doses received on or after 12 months of age if the applicant was born on or after September 15, 2003, unless the applicant has a reliable history of natural disease.[7]

[1] Mumps vaccine may be included in measles/rubella-containing vaccine.

[2] The 5th dose of DTaP is not necessary if the 4th dose was administered on or after 4 years of age.

[3] Applicants 7 through 18 years of age who received their 1st dose of diphtheria/tetanus/pertussis-containing vaccine before 12 months of age should receive a total of 4 doses, with one of those doses administered on or after 4 years of age.

[4] Applicants 7 through 18 years of age who received their 1st dose of diphtheria/tetanus/pertussis-containing vaccine at 12 months of age or older should receive a total of 3 doses, with one of those doses administered on or after 4 years of age.

[5] If an applicant received an all-inactivated poliovirus (IPV) or all-oral poliovirus (OPV) series, a 4th dose is not necessary if the 3rd dose was administered on or after 4 years of age.

[6] If both OPV and IPV were administered as part of the series, a total of 4 doses are required, regardless of the applicant's current age.

[7] Administer 2 doses of varicella vaccine, at least 3 months apart, to applicants less than 13 years of age. Do not repeat the 2nd dose if administered 28 days or greater from the 1st dose. Administer 2 doses of varicella vaccine to applicants 13 years of age or older at least 4-weeks apart. The minimum interval between the 1st and 2nd dose of varicella for an applicant 13 years of age or older is 28 days.